STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	**425 S JOLIET ST STE 312 DYER, IN 46311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This was a home health extended federal complaint investigation. Complaints: IN00148328 and IN00148240 - Substantiated: Federal deficiencies related to the allegation are cited. Survey Date: May 28 - June 3, 2014 Facility #: 007377 Medicaid #: 200873250 Surveyors: Ingrid Miller, MS, BSN, RN Public Health Nurse Surveyor Incare Home Healthcare Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning June 3, 2014, to June 3, 2016, due to being found out of compliance with the Conditions of Participation 42 CFR 484.10 Patient Rights; 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; 484.30 Skilled Nursing Services; 484.36 Home health aide services; and 484.55 Comprehensive Assessment of Patients. The Administrator informed of the above-stated preclusion on June 2, 2014, at 11:40 AM. Quality Review: Joyce Elder, MSN, BSN, RN June 13, 2014	G 000		
G 100	484.10 PATIENT RIGHTS This CONDITION is not met as evidenced by:	G 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 100	Continued From page 1 Based on clinical record and agency policy review, agency document review, and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure the patient's right to dignity was maintained for 3 of 12 records reviewed with the potential to affect all 72 patients of the agency (see G 101); failing to follow their own policy to investigate complaints and document the existence and resolution of the complaint for 1 of 1 agency reviewed with the potential to affect all of the patients served by the agency (see G 107); failing to ensure the patient was informed in advance of any changes in the care to be furnished in 3 of 12 records reviewed with the potential to affect all the agency's patients (see G 108); and failing to to ensure the patient's right to confidential clinical record information had been protected when employee I shared her password to access clinical information with another person for 1 of 1 agency creating the potential to affect all of the agency's 72 current patients (see G 111). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 42 CFR 484.10 Patient Rights.	G 100		
G 101	484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. This STANDARD is not met as evidenced by: Based on interviews and review of policy, clinical records, and agency documents, the agency failed to ensure the patient's right to dignity was	G 101		

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G 101	Continued From page 2	G 101		

maintained as identified in the agency's "Patient's Bill of Rights and Responsibilities" for 3 of 12 records reviewed (patient #20, #21, #22).

Findings

1. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the ... patient has the right to be informed about the care to be furnished, and of any changes in the care to be furnished as follows ... the patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."

2. The agency admission package contained an undated document titled "Patient Bill of Rights and Responsibilities."

3. On 6/2/14 at 3:45 PM, patient #20 indicated having a complaint with a home health aide (HHA). The HHA had given him / her a choice of bath or having the bed made and not a choice of having both tasks done. The plan of care for the certification period 4/5/15-6/3/14 failed to identify anything the aide was to do except make visits. The HHA, Employee D, had only visited twice. The patient had complained to the office about the care and asked to not have the aide return. This complaint had not been documented in the complaint log.

A review of clinical record #20 evidenced the patient had signed the patient rights at the start of care on 4/5/14.

4. On 6/3/14 at 7:45 AM, patient #21 indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

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G 101	Continued From page 3 not knowing that he / she was receiving services from the home health agency. The record failed to evidence the agency had infomred patient #21 that they were to receive services or that the patient had been discharged. A review of clinical record #21 indicated the patient had signed the patient rights on 10/3/13. 5. On 6/3/14 at 10:20 AM, patient #22's caregiver indicated Employee T, HHA, had stated, "If you want [patient #22] to get a shower, you will have to put [patient #22] in there yourself and then I will shower [the patient] when I arrive." A review of clinical record #22 indicated that the patient had signed the patient rights on 10/1/13. 6. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the ... patient has the right to be informed about the care to be furnished, and of any changes in the care to be furnished as follows ... the patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."	G 101		
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both	G 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 107	Continued From page 4	G 107		

the existence of the complaint and the resolution of the complaint.

This STANDARD is not met as evidenced by:
Based on policy review, clinical record review, administrative document review, and interview, the agency failed to follow their own policy to investigate complaints and document the existence and resolution of the complaint for 5 of 12 records reviewed with the potential to affect all of the patients served by the agency. (#12, 14, 19, 20, and 22)

Findings include

1. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as a patient of the home health agency as follows ... the patent has the right to place a complaint with the department regarding treatment or care furnished by a home health agency ... to voice complaints about care or treatment ... the organization investigates the complaint and resolution of the same."

2. The agency admission package contained an undated document titled "Patient Bill of Rights and Responsibilities."

3. Clinical record #12, start of care 10/23/13, evidenced the patient had received the patient rights at the start of care and failed to have a complaint documented, investigated, or resolved. The complaint log failed to evidence the complaint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 107	Continued From page 5	G 107		

On 4/23/14 at 4:23 PM, the patient indicated having a complaint that had not been addressed by the administrator. The patient had complained of not receiving aide visits as ordered on the plan of care.

4. Clinical record #14, start of care 8/12/13, evidenced the patient had received the patient rights at the start of care and failed to have a complaint documented, investigated, or resolved. The complaint log failed to evidence the complaint.

a. On 5/28/14 at 7 PM, patient #14 indicated that nursing services were stopped without any notice. Patient #14 indicated filing a complaint with the office personnel and requested that Employee A, the administrator and director of nursing, investigate the complaint. This never occurred despite patient #14's numerous phone calls to the office and being told that the person that the patient needed to speak to was Employee A. At one call, the office staff put the call on speaker phone and patient #14 could hear Employee A talking about not having time to call patient #14 and complaining that the patient called several times. Employee A indicated on the speaker phone her intentions to call when the meeting occurring was done and at that time she would return call, but she never did return a call and never did investigate or resolve the patient's complaint. Patient #14 indicated needing supplies for an abdominal fistula dressing and did not receive any more of these supplies when the agency staff stopped visits without notice or discussing this failure to visit with her / him. Patient #14 indicated being on home hemodialysis at the start of care with the agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	**425 S JOLIET ST STE 312 DYER, IN 46311**

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G 107	Continued From page 6	G 107		

b. On 5/29/14 at 10:25 AM, Employee C, Registered Nurse indicated the complaint had not been filed in the complaint log.

5. Clinical record #19, start of care 4/5/2014, had received the patient rights at the start of care and had not had a complaint documented, investigated, or resolved. The complaint log failed to evidence the complaint

On 6/2/14 at 2:10 PM, patient #19 complained that the physical therapist had called and canceled and had said that a visit would occur that weekend. No visit had occurred. The patient indicated calling the office and complaining and that no follow- up had occurred.

6. On 6/2/14 at 3:45 PM, patient #20 indicated having a complaint with a home health aide (HHA). The HHA had given him / her a choice of bath or having the bed made and not a choice of having both tasks done. The HHA, Employee D, had only visited twice. The patient had complained to the office about the care and asked to not have the aide return. This complaint had not been documented in the complaint log.

A review of clinical record #20 evidenced the patient had signed the patient rights at the start of care on 4/5/14.

7. Clinical record #22, start of care 10/1/13, evidenced the patient had received the patient rights at the start of care and failed to have a complaint documented, investigated, or resolved. The complaint log failed to evidence the complaint.

On 6/3/14 at 11 AM, the power of attorney for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

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G 107	Continued From page 7 patient #22 and informal caregiver of patient #22 indicated calling Employee A with a complaint that the patient was receiving sponge baths and not showers that had been agreed upon. He/she indicated receiving no follow up with his complaint. In February, the power of attorney had also complained and requested that any time the plan of care was altered or days were changed that he /she should be contacted. There was no follow up with this complaint. The power of attorney indicated last week to talk to the administrator about the patient not receiving showers as requested and getting no response. 8. A review of the complaint log failed to evidence any investigation or other documentation concerning the complaint filed by patient #12, #14, #19, #20, #22.	G 107		
G 108	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. This STANDARD is not met as evidenced by: Based on policy review, agency document review, interview, and clinical record review, the agency failed to ensure the patient was informed	G 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	**425 S JOLIET ST STE 312 DYER, IN 46311**

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G 108	Continued From page 8	G 108		

in advance of any changes in the care to be furnished in 3 of 12 records reviewed (#14, #21, #22).

Findings include

1. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The home health agency must protect and promote the exercise of these rights as follows ... the patient has the right to exercise his or her rights as a patient of the home health agency as follows ... the patient has the right to be informed about the care to be furnished and of changes in the care to be furnished ... the home health agency shall advise the patient in advance of disciplines that will furnish care, and the frequency of visits proposed to be furnished ... the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice."

2. The agency admission package contained a n undated document titled "Patient Bill of Rights and Responsibilities."

3. Clinical record #14, start of care 8/12/13, evidenced the patient had received the patient rights at the start of care and was not aware of the discharge of services that occurred in March 2014.

a. On 5/28/14 at 7 PM, patient #14 indicated that nursing services were stopped without any notice in early March 2014. Patient #14 indicated filing a complaint with the office personnel and requested that Employee A, the administrator and director of nursing, investigate the complaint. This never occurred despite patient #14's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	**425 S JOLIET ST STE 312 DYER, IN 46311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 108	Continued From page 9	G 108		

numerous phone calls to the office and being told that the person that the patient needed to speak to was Employee A. At one call, the office staff put the call on speaker phone and patient #14 could hear Employee A talking about not having time to call patient #14 and complaining that the patient called several times. Employee A indicated on the speaker phone her intentions to call when the meeting occurring was done and at that time she would return call, but she never did return a call and never did investigate or resolve the patient's complaint. Patient #14 indicated needing supplies for an abdominal fistula dressing and did not receive any more of these supplies when the agency staff stopped visits without notice or discussing this failure to visit with her / him. Patient #14 indicated being on home hemodialysis at the start of care with the agency.

b. On 5/29/14 at 10:25 AM, Employee C, Registered Nurse (RN), indicated the patient was not informed of the discharge.

4. On 6/3/14 at 7:45 AM, patient #21 indicated not knowing he / she was receiving services from the home health agency. Patient #21 indicated not being aware of being discharged. The plan of care dated 02-01-14 to 04-01-14 evidenced orders for the aide to assist with activities of daily living and personal care and hygiene. All the aide care plans (The most recent one dated 3/25/14.) identified the aide was to have a tub or shower bath. The record failed to evidence a subsequent plan of care or that the patient had been discharged.

a. A review of clinical record #21 indicated that the patient had signed the patient rights on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 108	Continued From page 10 10/3/13. b. On 6/3/14 at 10:25 AM, Employee W, RN, indicated that patient #21 was not receiving the baths because instead patient #22, who lived in the same household, received these baths. This was done for convenience, he indicated. 5. On 6/3/14 at 10:25 AM, Employee W, RN, indicated that patient #22 was the only one of patients #21 and #22 receiving home health aide services. Patient #21's visits were used for patient #22. Employee W indicated he was the primary nurse visiting patient #22 and conducting aide supervision. A review of patient #22's file showed the patient had signed the rights at the start of care on 10/1/13. 6. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The home health agency must protect and promote the exercise of these rights as follows ... the patient has the right to exercise his or her rights as a patient of the home health agency as follows ... the patient has the right to be informed about the care to be furnished and of changes in the care to be furnished ... the home health agency shall advise the patient in advance of disciplines that will furnish care, and the frequency of visits proposed to be furnished ... the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice."	G 108		
G 111	484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS	G 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 111	Continued From page 11	G 111		

The patient has the right to confidentiality of the clinical records maintained by the HHA.

This STANDARD is not met as evidenced by:
Based on policy review and text and document review and interview, the agency failed to ensure the patient's right to confidential clinical record information had been protected when employee I shared her password to access clinical information with another person.

The findings include:

1. The agency policy titled "Patient Privacy Rights" with no effective date stated, "Patient privacy rights will be presented to all patients at the time of admission with the Home Care Bill of Rights ... to inform patients of the agency of their rights of privacy. To accommodate patient privacy rights as specified in the privacy rule of the Health Information and Accountability Act regulation."

2. These are text exchanges from the complainant to Employee I, Registered Nurse. The texts are documented in printed form via email and corroborated with the employee roster phone numbers and staff interview.

a. On 4/1/14 at 6:33 PM unknown person texted to Employee I, "Please call me. You have errors in your cert for [patient #7]"

b. From Complainant to Employee I at 7:45 PM, "That's not the right password."

c. From Employee I at 7:50 PM, [password given].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

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INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

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G 111	Continued From page 12 d. From complainant at 7:50 PM, " Thank you dear." e. On 4/2/14 at 12:14 PM, From complainant to Employee I , " Are going to be seeing [patient #17] today?" 3. On 5/30/14 at 3:15 PM, Employee I wrote her AXXESS password on an envelope. (This matched the texted password noted in the complaint documents.) 4. On 6/3/14 at 3:35 PM, Employee I indicated the text was from her phone. She indicated she would only share passwords with Employee A (the administrator / director of nursing), the owner's wife, and Employee R, the owner.	G 111		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, interview, and review of procedures, the agency failed to ensure staff had provided services in accordance with the agency's policies regarding bag technique in 2 of 2 home visit observations (patient #19 and #20) completed. The findings include 1. On 6/2/14 at 2:10 PM, Employee E, home	G 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 121	Continued From page 13 health aide, was observed to place her supply bag on patient #19's couch without a barrier. 2. On 6/2/14 at 3:45 PM, Employee I, registered nurse, was observed to place her nursing bag on patient #20's bed. After using her stethoscope and blood pressure cuff to assess patient #20, she replaced these supplies in the bag without disinfecting them. 3. The agency procedure titled "Competency Evaluation - Supply Bag Technique" with no effective date stated, "Bag placed on surface or hung from chair. Barrier utilized, if appropriate ... Equipment cleaned prior to returning to bag, as appropriate." 4. On 6/3/14 at 11:55 AM, the administrator indicated the visits above had not followed infection control standards.	G 121		
G 133	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. This STANDARD is not met as evidenced by: Based on clinical record review, agency document and policy review, other document review, observation, and interview, the administrator failed to be knowledgeable about	G 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 14	G 133		

the agency's patients to organize and direct the agency's functions for 7 of 12 records (record #14 - #18, #21, #22) reviewed.

The findings include

Regarding clinical record #14

1. Clinical record #14 evidenced skilled nursing services had been provided 1 - 2 times a week for 9 weeks during the certification period of 12/10/13 - 2/7/14 and also were provided on 2/18/14 and 3/7/14. The patient had been transferred to the hospital on 2/21/14 and returned home on 2/23/14. Neither a transfer or discharge had occurred to show that the patient had been discharged and no resumption of care had occurred when the patient returned home. However, an oasis start of care assessment was completed by the RN on 2/26/14. The record was observed kept as a closed record in a file cabinet for closed records on 5/30/14 at 9:10 AM, but failed to evidence any discharge assessment or discharge summary had been completed or that a resumption of care had been completed. It was not known that the patient had been discharged.

a. A document titled "Community Healthcare System" dated 2/21/14 evidenced the patient had been hospitalized from 2/21/14 - 2/23/14 for a failing permacath.

b. On 5/28/14 at 7 PM, patient #14 indicated that services stopped and that he / she had not been notified of this change in the plan of care.

c. On 5/30/14 at 9:10 AM, Employee C indicated no hospital transfer or discharge oasis had been completed at patient #14's end of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

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G 133	Continued From page 15	G 133		

This was not following policy. Employee C indicated the patient had signed the patient rights and had signed consent for a new start of care on 2/26/14 and had been visited by the skilled nurse. There were no orders and no plan of care for this care provided.

d. On 5/30/14 at 2:26 PM, Employee C indicated the patient had been discharged from the agency and there was no discharge assessment or discharge summary. The patient had been transferred to the hospital on 2/21/13 and returned home on 2/23/14. There was no resumption of care.

Regarding clinical record #15

2. Clinical record #15, start of care (SOC) 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 2/19/14 - 4/19/14 and 4/20/14 - 6/18/14. The plan of care for 2/19/14 - 4/19/14 was signed on 5/19/14 by the physician. This record evidenced the home health aide was to visit two times a week for 9 weeks for these certification period. According to employee A on 5/29/14 at 12:05 PM, the home health aide had been visiting the patient but had not turned in documentation since December 2013. The administrator was aware but the concern was not corrected or documented.

a. The plan of care for patient #15 for the certification periods of 2/19/14 - 4/19/14 and 4/20/14 - 6/18/14 evidenced the home health aide was to visit two times a week for 9 weeks for these certification period. On 5/29/14 at 12:05 PM, Employee A was called by phone with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 16	G 133		

Employee C and Employee R present. Employee A indicated that Employee C was sent to patient #15's home to check if Employee S, home health aide (HHA), was still caring for this patient under the agency's care. Employee A indicated that Employee S had terminated earlier this year, but did not give a date of termination. Employee A stated, "Why she never reported this, I don't know. There is a physician order, but she maintains contact with the patient. This is under investigation with our consultant." Employee A indicated that Employee I, registered nurse (RN), is responsible for this. Employee A indicated that Employee I has made progress in her work with the agency but still needs to make improvement with documentation with her care of the patients. Employee A indicated that Employee I does supervise the home health aides well and was in charge of supervision of this aide. The patient was pleased with this care from the agency.

b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.

c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Employee C indicated that she was sent in by Employee A to check on the services of an Employee S, HHA. Employee C indicated not knowing Employee S had resigned. She only knew that no documentation had been sent in for months from the Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 17	G 133		

d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and Employee C. She indicated still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient that she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in trouble.

e. A clinical document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13." This included the signature of Employee A, administrator.

f. Three clinical documents were evidenced to be home health aide care plans and were dated on 12/18/13, 2/18/14, and 4/18/14.

Regarding clinical record #16

3. Clinical record #16, SOC 10/23/13 and a diagnosis of bronchitis, included a plan of care for the certification period of 4/21/14 - 6/19/14 and was an active record. However, the patient had been transferred on 5/16/14 and then discharged. The patient was listed on the active patients list on 5/28/14. However, the clinical record was closed.

a. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #16's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 18	G 133		

name, medicare #, date of birth, SOC date as 10/23/13 and certification period of 4/21/14 - 6/19/14, diagnosis of bronchitis, and disciplines of skilled nursing and home health aide.

b. On 6/2/14 at 10:25 AM, Employee A indicated the discharge was pending in the computer software program called AXXESS, since she was still learning the features of the program.

Regarding clinical record #17

4. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #17's name, medicare #, date of birth, SOC date as 2/2/14 and certification period of 4/3/14 - 6/1/14, diagnosis of benign hypertension, and disciplines of skilled nursing and home health aides.

a. On 5/29/14 at 12:15 PM, Employee C, the alternate administrator, was unable to find patient #17's record.

b. On 5/30/14 at 11:40 AM and at 1:10 PM, Employee C was unable to find patient #17's record.

c. On 5/30/14 at 4 PM, the owner of the agency, Employee R, found the clinical record in the discharged records. The patient's last home health aide visit had occurred on 4/29/14 and the patient had been transferred to the hospital on that date. There was no transfer or discharge assessment evidenced in the clinical record.

d. On 5/30/14 at 4:30 PM, Employee I,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 19	G 133		

Registered Nurse, indicated the patient had been transferred to the hospital on 4/29/14 and was now discharged. No transfer or discharge assessment or summary had been completed.

e. On 6/3/14 at 1:35 PM, Employee A, the administrator, indicated the patient was discharged and not active as indicated.

Regarding Clinical record #18

5. On 5/28/14 at 3:45 PM, Employee C indicated that patient #18's record was not able to be found. On 6/2/14 at 12:20 PM, Patient #18's record was located and had a discharge summary and assessment. The administrator indicated patient #18's record was complete.

Regarding Clinical record #21 and #22

6. Clinical record #21, SOC 10/4/13 and discharge on 3/25/14 and diagnosis of brain neoplasm, included a plan of care for the certification period of 2/1/14 - 4/1/14. The payment source was listed as Medicare. This plan of care indicated the patient was to receive skilled nurse visits 1 - 2 times weekly for 9 weeks and HHA visits for personal care including showers 1 - 2 times a week for 9 weeks. There were also HHA visits documented for 3/25/14, 4/3/14, 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, and 4/24/14 after the discharge of this patient. There was an aide care plan dated on 1/30/14 that had no tasks for the home health aide to complete.

7. Clinical record #22, SOC 10/1/13 and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 20	G 133		

diagnosis of paraplegia, included a plan of care for the certification period of 3/30/14 - 5/28/14 and payment source as Medicare. Included in the record were HHA visits from record #21 with the name of patient #21 documented. Ordered on this plan of care was the skilled nurse frequency of 1 time a week for 9 weeks and HHA 2 times a week x 9 weeks. HHA visits occurred on 4/2/14, 4/4/14, 4/8/14, 4/10/14, 4/15/14, 4/17/14, 4/23/14, 4/25/14, 4/29/14, 4/30/14, 5/1/14, 5/7/14, 5/9/14, 5/13/14, and 5/15/14. Skilled nurse visits occurred on 3/25/14, 4/10/14, 4/23/14, 4/30/14, 5/7/14, 5/14/14, and 5/21/14. HHA visits for patient #21 were also in this record. These were from the following dates: 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, 4/24/14, 4/30/14, and 5/2/14.

On 6/3/14 at 1:05 PM, the administrator indicated that she was looking into this situation with patients #21 and #22. She stated, "We are not benefiting from this. [The patient] has private pay."

8. The agency policy titled "Clinical documentation" with no effective date stated, "Agency will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the patient's care ... to ensure that there is an accurate record of the services provided, patient response and ongoing need for care ... to document conformance with the plan of care, modifications to the plan, and interdisciplinary involvement ... documentation of the services ordered on the plan of care will be completed the day service is rendered and incorporated into the clinical record within 7 days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 133	Continued From page 21 after the care has been provided."	G 133		
G 141	484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. This STANDARD is not met as evidenced by: Based on personnel file and policy review and interview, the agency failed to ensure the personnel policies were followed in 4 of 7 employee files reviewed (S, U, X, Y) with the potential to affect all the patients of the agency. Findings 1. Employee S, home health aide (HHA), date of hire 8/10/07 and unknown first patient contact, failed to evidence an annual evaluation had been completed since 2012. 2. Employee U, HHA, date of hire 4/9/09 and first patient contact in 2009, failed to include an annual evaluation since 2010 and a competency skills evaluation had been completed upon hire. 3. Employee X, Registered Nurse (RN) , date of hire 3/28/14 and first patient contact 4/10/14, failed to include a criminal history or completed physical examination. 4. Employee Y, RN, date of hire 3/21/14 and first patient contact 4/10/14, evidenced a criminal	G 141		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 141	Continued From page 22 history completed on 5/1/14 and a no physical examination had been completed. 5. The agency policy titled "Health Screening" with no effective date stated, "Each employee having direct documentation of baseline health screening prior to providing care to patients ... Preemployment physical examination will be performed by a physician or nurse practitioner as mandated by state law or agency policy." 6. The agency policy titled "Performance Evaluations" with no effective date stated, "A competency based performance evaluation will be conducted for all employees after 1 year of employment and at least annually thereafter." 7. The agency policy titled "Personnel Records" with no effective date stated, "Personnel files will be established and maintained for all personnel ... The personnel record for an employee will include ... criminal history and background checks as required by law [IC 16-27-2]." 8. The agency policy titled "Home Health Aide services" with no effective date stated, "Only home health aides who meet required standards will provide direct care." 9. On 5/29/14 at 12:21 PM, Employee C, RN, indicated the personnel records were not complete.	G 141		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 156	Continued From page 23 This CONDITION is not met as evidenced by: Based on clinical record and agency policy review, and interview, it was determined the agency failed to ensure patients needs were addressed and being met adequately by the agency in the patient's place of residence in 6 of 12 patient records reviewed creating the potential to affect all patients of the agency (See G 157), failed to ensure treatments and services had been provided in accordance with physician's orders in 8 of 12 records reviewed creating the potential to affect all of the agency's 72 active patients (See G 158), failed to ensure the plan of care was signed by the physician timely and included all required elements for 8 of 12 records reviewed with the potential to affect all the agency's patients (See G 159), and failed to ensure the agency staff promptly alerted the physician to any changes that suggested a need to alter the plan of care for 1 of 12 records reviewed with the potential to affect all of the agency's active patients (See G 164). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.	G 156		
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.	G 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	**425 S JOLIET ST STE 312 DYER, IN 46311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 24	G 157		

This STANDARD is not met as evidenced by:
Based on agency document review, clinical record review, policy review, and interview, the agency failed to ensure patients needs were addressed and being met adequately by the agency in the patient's place of residence in 6 of 12 patient records (12, 14, 16, 17, 19, 22) reviewed.

Findings include:

1. Clinical record #12, start of care (SOC) 10/23/13, included a plan of care for the certification period of 4/21/14 - 6/19/14 with orders for home health aide (HHA) 1 - 2 times a week for 9 weeks. However, no visits occurred until May 14, 2014.

a. On 4/23/14 at 4:23 PM, the patient indicated having a complaint that had not been addressed by the administrator. The patient had complained of not receiving aide visits as ordered on the plan of care and not having his / her needs met.

b. On 5/29/14 at 10:12 AM, Employee C, Registered Nurse (RN), indicated the plan of care had not been followed and HHA visits were missing from the clinical record.

2. Clinical record #14, start of care 8/12/13, evidenced the patient had received the patient rights at the start of care and failed to have a complaint documented, investigated, or resolved and the patient was not told of a pending discharge or ceasing of services.

a. On 5/28/14 at 7 PM, patient #14 indicated that nursing services were stopped without any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	**425 S JOLIET ST STE 312 DYER, IN 46311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 25	G 157		

notice in early March 2014. Patient #14 indicated filing a complaint with the office personnel and requested that Employee A, the administrator and director of nursing, investigate the complaint. This never occurred despite patient #14's numerous phone calls to the office and being told the person the patient needed to speak to was Employee A. At one call, the office staff put the call on speaker phone and patient #14 could hear Employee A talking about not having time to call patient #14 and complaining that the patient called several times. Employee A indicated on the speaker phone her intentions to call when the meeting occurring was done and at that time she would return call, but she never did return a call and ever did investigate or resolve the patient's complaint. Patient #14 indicated needing supplies for an abdominal fistula dressing and did not receive any more of these supplies when the agency staff stopped visits without notice or discussing this failure to visit with her / him. Patient #14 indicated being on home hemodialysis at the start of care with the agency.

b. On 5/29/14 at 10:25 AM, Employee C, RN, indicated the patient's needs had not been met.

3. Clinical record #16, start of care 10/23/13 and diagnosis of bronchitis, included a plan of care for the certification period of 4/21/14 - 6/19/14 which failed to evidence the patient's needs had been met. The patient had a Social Worker (MSW) Evaluation ordered on 4/21/14. The record failed to evidence that the physician was notified of the patient's refusal for the social work visit. No community resources were made available to the patient. No social work interventions occurred. The director of nursing was contacted and did not write any notes in this clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 26	G 157		

a. On 4/10/14 at 6:52 PM, the home physician wrote the following clinical note: "Patient needs to have a more appropriate and safe living situation. Will order social services ... patient needs place in a skilled facility ... cannot move and lives alone."

b. On 4/18/14 at 5:15 PM, the licensed practical nurse (LPN), Employee C, stated in a clinical note, "Will contact SS [Social Services regarding living conditions]." The record failed to evidence this occurred.

c. A clinical note written by Employee W, registered nurse (RN), on 5/13/14 at 11:35 AM under Care coordination to Employee A, director of nursing, "Patient needs evaluation by home MD for possible assisted living or nursing home placement. Need for MSW also relayed. Current frequency for SN [skilled nurse] and HHA needs to be increased. MD and DON [director of nursing] to see patient this PM."

d. On 6/2/14 at 11:05 AM, the administrator indicated the patient had refused social work services and there was no documentation about this refusal or when this refusal occurred.

e. On 5/16/14 at 11:30 AM, a clinical note written by Employee W, Registered Nurse, stated, "Pt [patient] assessment ... lethargic but arouseable ... 911 notified for ambulance transfer condition report given." Patient was transferred to hospital.

4. Clinical record #17, SOC 10/2/12 with a certification period of 4/3/14 - 6/1/14 included an order on the plan of care that stated, "Physician's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 27	G 157		

order, 4/2/14, MSW eval [evaluation]" This was dated 4/2/14 and signed by Employee A, administrator and director of nursing, and not signed by the physician.

a. On 5/30/14 at 4 PM, Employee I, Registered Nurse, indicated the patient had fallen on 4/24/14 and then cut self on arms on 4/29/14 with a knife. Employee E, the home health aide, called with an update and employee I called the physician. Employee I did not write any notes on this incident and did not write a transfer oasis. An informal caregiver took the patient to the emergency room where the patient was admitted and stayed several days.

b. On 5/30/14 at 4:45 PM, Employee C, the alternate administrator indicated the social work evaluation was not in the record.

c. On 6/3/14 at 1:30 PM, Employee A indicated the patient had refused to see a social worker. There was no order or other communication to the doctor about this refusal.

5. Clinical record #19, start of care 4/5/2014, had received the patient rights at the start of care and had not had a complaint documented, investigated, or resolved.

On 6/2/14 at 2:10 PM, patient #19 complained that the physical therapist had called and canceled and had said that a visit would occur that weekend. No visit had occurred. The patient indicated calling the office and complaining and that no follow- up had occurred.

6. Clinical record #22, start of care 10/1/13, evidenced the patient had received the patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	**425 S JOLIET ST STE 312 DYER, IN 46311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 157	Continued From page 28	G 157		

rights at the start of care and failed to have a complaint documented, investigated, or resolved.

On 6/3/14 at 11 AM, the power of attorney for patient #22 and informal caregiver of patient #22 indicated calling Employee A with a complaint that the patient was receiving sponge baths and not showers that had been agreed upon. He/she indicated receiving no follow up with his complaint. In February, the power of attorney had also complained and requested that any time the plan of care was altered or days were changed that he /she should be contacted. There was no follow up with this complaint. The power of attorney indicated last week to talk to the administrator about the patient not receiving showers as requested and getting no response.

8. A review of the complaint log failed to evidence any investigation or other documentation concerning the complaint filed by patient #12, #14, #19, #20, #22.

9. The agency policy titled "Patient Admission Process" with no effective date stated, "If the agency cannot fulfill the required health need, a referral will be made to other appropriate community resources and referral source will be notified."

10. The agency document titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "Be admitted only if we can provide the care you need."

11. The agency admission package contained a document titled "Patient Bill of Rights and Responsibilities."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 29	G 158		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure services and treatments had been provided in accordance with physician's orders in 8 of 12 records reviewed (#7, 12, 13, 14, 15, 16, 19, 20) creating the potential to affect all of the agency's 72 current patients. Findings 1. Clinical record #7, start of care (SOC) 7/26/13 with a diagnosis of Congestive Heart Failure, included a plan of care for the certification period of 3/23/14 - 5/21/14 with orders for occupational therapy (OT) visits. The orders failed to include frequency for the visits which occurred on 3/25/14, 3/27/14, 4/3/14, 4/8/14, and 4/10/14. Skilled nurse visits were also ordered on the plan of care. A nurse visit on 4/11/14 at 9 AM, failed to show that the nurse had completed the tasks ordered on the plan of care including assessing for edema and peripheral circulation. The nurse failed to complete a body system assessment that was ordered. The nurse failed to complete a pain assessment. On 5/20/14 at 2:55 PM, Employee C, Registered Nurse (RN) indicated the visits above did not follow the plan of care.	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 30	G 158		

2. Clinical record #12, SOC 10/23/13 with a diagnosis of benign hypertension, evidenced no plan of care for the certification period of 4/21/14 - 6/19/14 on 5/29/14 at 10:15 AM. On 6/2/14 at 10 AM, the clinical record did contain a plan of care for the certification period of 4/21/14 - 6/19/14. This plan of care evidenced the skilled nurse was to visit the patient 1 times a week for 9 weeks to assess pain level, instruction on shortness of breath, weekly weights, assess and instruct on pain management, proper body mechanics and safety measures, to instruct on proper foot wear when ambulating, and to encourage the patient to see a podiatrist. No skilled nurse visits were completed in the clinical record. The home health aide was to visit 1 - 2 times a week for assist with activities of daily living. The only aide visit notes in the record were on 5/14/14 and 5/16/14. No other aide notes were present for the current certification period.

a. On 5/29/14 at 10:15 AM, Employee C indicated the plan of care had not been completed and was not part of the clinical record and skilled nurse visits and home health aide visits were not in the record.

b. On 5/29/14 at 2:00 PM, Employee I, registered nurse (RN), was observed to have a piece of paper with visit notes for the past two months noted on this paper. She indicated she did not document the visit until later at home. This paper was divided into about 8 sections and vital signs and the date were recorded. The paper did not indicate what part of the plan of care had been completed besides vital signs. There was no pain assessments or instructions for proper foot wear noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 31	G 158		

c. On 6/3/14 at 2 PM, Employee A indicated the skilled nurse visits were missing from the record and documentation of a visit should be on a visit note or in the software program for skilled nurse visits used by the agency. Employee A indicated Employee I had not been documenting her skilled nurse visits timely or according to policy.

3. Clinical record #13, SOC 3/29/14, evidenced a plan of care for the certification period of 3/29/14 - 5/27/14 that was electronically signed by Employee I on 3/25/14. The physician signed this plan of care on 5/10/14. Skilled nurse visits were made on 4/15/14, 4/22/14, 4/29/14, 5/9/14, 5/17/14, 5/20/14, and 5/27/14. There was no frequency of skilled nurse visits on this plan of care.

On 5/30/14 at 2:25 PM, Employee C indicated the skilled nurse had not followed the plan of care.

4. Clinical record #14 with a diagnosis of wound disruption evidenced two starts of care. One occurred on 8/12/13 and the other on 2/26/14. The record evidenced a plan of care for the certification period of 12/10/13 - 2/7/14, which was signed on 1/16/14. There was no other plan of care after this certification period. There were no orders for skilled nurse visits which were documented on 2/18/14 and 3/7/14. An oasis start of care assessment was completed by the RN on 2/26/14.

On 5/30/14 at 9:45 AM, Employee C indicated there were no orders on the plan of care for the skilled nurse visits that occurred on 2/18/14 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 32	G 158		

3/7/14 and the oasis start of care assessment completed by the RN on 2/26/14.

5. Clinical record #15, SOC 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 12-21-13 - 2-18-14 (HHA to visit 1 - 2 times a week and skilled nurse 1 - 2 times a week), 2/19/14 - 4/19/14 (HHA 2 times a week and skilled nurse (SN) 1 times a week) and 4/20/14 - 6/18/14 (SN one times a week). The plan of care for 2/19/14 - 4/19/14 was signed on 5/19/14 by the physician. The home health aide had been visiting the patient but had not turned in documentation since December 2013. The administrator was aware but the concern was not corrected or documented. Home health aide visits had been made since December 2013 with no documentation in the record. Therefore, it could not be determined if they were made as ordered or whether the correct tasks were performed. The patient had physical therapy and occupational therapy visits ordered on 4/20/14 and 5/8/14 and these visits did not occur. There was no documentation in the record why these visits did not occur.

a. On 5/29/14 at 12:05 PM, Employee A was called by phone with Employee C and Employee R present. Employee A indicated that Employee C was sent to patient #15's home to check if Employee S, HHA, was still caring for this patient under the agency's care. Employee A indicated that Employee S had terminated earlier this year, but did not give a date of termination. Employee A stated, "Why she never reported this, I don't know. There is a physician order, but she maintains contact with the patient. This is under investigation with our consultant." Employee A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 33	G 158		

indicated that Employee I, RN, is responsible for this. Employee A indicated that Employee I has made progress in her work with the agency but still needs to make improvement with documentation with her care of the patients. Employee A indicated that Employee I does supervise the home health aides well and was in charge of supervision of this aide. The patient was pleased with this care from the agency.

b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.

c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Patient #15 was happy with the services from Incare and the aide. Employee C indicated that she was sent in by Employee A to check on the services of an Employee S, HHA. Employee C indicated not knowing that the Employee S had resigned. She only knew that no documentation had been sent in for months from the Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services.

d. On 5/30/14 at 11:55 AM, Employee S called via telephone and spoke to writer and Employee C. She indicated she was still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 34	G 158		

she had not turned in the notes and asked if she was in trouble.

e. On 5/30/14 at 1:10 PM, Employee C indicated the plan of care was not followed and the therapy visits never occurred.

f. A clinical document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13." This included the signature of Employee A, administrator.

g. Three clinical documents in the record were home health aide care plans and were dated on 12/18/13, 2/18/14, and 4/18/14.

6. Clinical record #16, start of care 10/23/13 and diagnosis of bronchitis, evidenced the skilled nurse used triple antibiotic ointment on the patient's skin tear on without obtaining an order on 5/13/14 at 11:35 AM. It was not documented where the skin tear was.

On 6/2/14 at 11:20 AM, Employee A, the administrator, indicated there was no order for this treatment.

7. Clinical record #19, SOC 4/17/14 and diagnosis of obstructive chronic bronchitis, included a plan of care for the certification period of 4/17/14 - 6/15/14. The record failed to evidence the patient had received the physical and occupational therapy visits ordered on 4/17/14.

On 6/3/14 at 2 PM, Employee A indicated these visits did not occur.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 35	G 158		

8. Clinical record #20, SOC 4/5/14 and a diagnosis of chronic airway obstructive, included a plan of care for the certification period of 4/5/14 - 6/3/14, evidenced orders for PT evaluation and treatment and OT evaluation and treatment. These visits had not occurred. A new order was written on 5/5/14 and an evaluation for PT occurred on 5/10/14. No OT visits occurred.

On 6/3/14 at 2:45 PM, Employee A, the administrator, indicated they had been locked out of the therapy site and could not access patient records.

9. The agency policy titled "Medical Supervision" with no effective date stated, "A physician plan of care is developed for each patient at the time of admission and signed by the physician in the appropriate time frame ... agency responsibilities include prompt reporting of a change in patient condition ... support of a physician plan of care."

10. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs."

11. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. The plan of care is based on a comprehensive assessment and information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 36 provided by the patient / family and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An individualized plan of care signed by the physician shall be required for each patient receiving home health and personal care services. The plan of care shall be completed in full to include ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care."	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care was signed by the physician timely and included all required elements for 8 of 12	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 37	G 159		

records reviewed (#7, 12, 13, 14, 15, 16, 17, 19) with the potential to affect all the agency's patients.

Findings

1. Clinical record #7, start of care (SOC) 7/26/13 with a diagnosis of Congestive Heart Failure, included a plan of care for the certification period of 3/23/14 - 5/21/14 that was not signed by the physician. The plan of care for the certification period of 5/22/14 - 7/20/14 had not been completed on 5/30/14 at 3 PM. The plan of care included orders for occupational therapy, but they lacked frequency of the visits. The medication list on the plan of care for these certification periods lacked the reason the medications were given for the as needed medications including polyethylene glycol and hydrocodone with Tylenol.

a. On 5/30/14 at 2:55 PM, Employee C, Registered Nurse (RN), indicated the plan of care was not completed by the physician and the new plan of care for the certification period was not complete. The occupational therapy orders lacked frequency of the visits.

b. On 5/30/14 at 3 PM, Employee C indicated the plan of care for the most recent certification period was not completed timely.

2. Clinical record #12, SOC 10/23/13 with a diagnosis of benign hypertension, evidenced that the physician had signed the plan of care for the certification period of 4/21/14 - 6/19/14 until 6/1/14. This plan of care failed to list the purpose of the as needed medications including hydrocodone / acetaminophen 10 - 325 mg (milligrams) every 6 - 8 hours as needed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 38	G 159		

ambien 5 mg oral tablet prn po (by mouth). Additionally, the ambien did not evidence how many tablets a day would be given and at what time of day the medication would be given.

a. On 5/29/14 at 10:15 AM, Employee C indicated the plan of care had not been signed in a timely manner.

b. On 5/30/14 at 2:55 PM, Employee C indicated the plan of care did not have the medications listed correctly.

3. Clinical record #13, SOC 9/30/13 with a diagnosis of chronic pain, included a plan of care for the certification period of 3/29/14 - 5/27/14 and also for 5/28/14 - 7/26/14 which failed to evidence a complete medication list. Fentanyl patch was listed without the dose, frequency, or route of administration. The plan of care for 5/28/14 - 7/26/14 evidenced the skilled nurse was to assess the patient's pain level and effectiveness of pain medications and current pain management therapy at every visit. Skilled nurse was to instruct patient to take pain medication before becomes severe to achieve better pain control. There were no measurable pain assessments or goals listed on this plan of care to measure the outcomes of the interventions.

On 5/30/14 at 2:26 PM, Employee C indicated the medication list on the plan of care failed to include the dose, frequency, and route of administration for the medication: Fentanyl and that no measurable goals were listed to assess the patient's pain levels and understanding of the teaching with pain control that was to occur.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 39	G 159		

4. Clinical record #14 with a diagnosis of wound disruption evidenced two starts of care. One occurred on 8/12/13 and the other on 2/26/14. The record evidenced a plan of care for the certification period of 12/10/13 - 2/7/14 which was not signed by the physician until 1/16/14. There was no other plan of care after this certification period. There were no orders for skilled nurse visits which were documented on 2/18/14 and 3/7/14. An oasis start of care assessment completed by the RN on 2/26/14.

On 5/30/14 at 9:45 AM, Employee C indicated there was no plan of care for the skilled nurse visits that occurred on 2/18/14 and 3/7/14 and the oasis start of care assessment completed by the RN on 2/26/14.

5. Clinical record #15, SOC 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 12-21-13 - 2-18-14 (HHA to visit 1 - 2 times a week and skilled nurse 1 - 2 times a week), 2/19/14 - 4/19/14 (HHA 2 times a week and SN 1 times a week) and 4/20/14 - 6/18/14 (SN one times a week). The plan of care for 2/19/14 - 4/19/14 was not signed until 5/19/14 by the physician.

A clinical document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13." This included the signature of Employee A, administrator.

6. Clinical record #16, start of care 10/23/13 and diagnosis of bronchitis, included a plan of care for the certification period of 4/21/14 - 6/19/14. This plan of care was not signed by the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 40	G 159		

On 6/2/14 at 11:06 AM, Employee A, administrator, indicated the plan of care was not signed.

7. Clinical record #17, start of care 10/2/12 with a certification period of 4/3/14 - 6/1/14 failed to evidence the frequency of skilled nurse visits which occurred on 4/3/14, 4/9/14, 4/16/14, 4/23/14, and 4/24/14. This plan of care was not signed by the physician.

a. On 5/30/14 at 1:15 PM, Employee C indicated the plan of care was not signed.

b. On 6/3/14 at 1:30 PM, Employee A indicated the frequency of skilled nurse visits was not included on the plan of care.

8. Clinical record #19, SOC 4/17/14 and diagnosis of obstructive chronic bronchitis, included a plan of care for the certification period of 4/17/14 - 6/15/14. This plan of care was not signed until 5/27/14 by the physician.

On 6/3/14 at 2:15 PM, Employee A indicated the plan of care was not signed in a timely manner.

9. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An individualized plan of car signed by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 41 physician shall be required for each patient receiving home health and personal care services. The plan of care shall be completed in full to include ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care."	G 159		
G 168	484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: Based on clinical record and agency policy review and interview, it was determined the agency failed to ensure skilled nursing services had been provided in accordance with physician's orders in 5 of 12 records reviewed creating the potential to affect all of the agency's 72 current patients (See G 170) failed to ensure a comprehensive assessment had been completed within 48 hours of the patient's return home from a hospital admission of 24 hours or more in 1 of 12 records reviewed creating the potential to affect all the patients who were hospitalized (See G 172), and failed to ensure the registered nurse coordinated patient care for 7 of 12 records reviewed and promptly alerted the physician to any changes that suggested a need to alter the plan of care for 1 of 12 records reviewed with the potential to affect all of the agency's active patients (See G 176).	G 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 168	Continued From page 42 The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.30 Skilled Nursing Services.	G 168		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nursing services had been provided in accordance with physician's orders in 5 of 12 records reviewed (#7, 12, 13, 14, 16) creating the potential to affect all of the agency's patients that receive skilled nursing services. Findings 1. Clinical record #7, start of care (SOC) 7/26/13 with a diagnosis of Congestive Heart Failure, included a plan of care for the certification period of 3/23/14 - 5/21/14. A nurse visit on 4/11/14 at 9 AM failed to show that the nurse had completed orders on the plan of care including assessing for edema and peripheral circulation. The nurse failed to complete a body system assessment that was ordered. The nurse failed to complete a pain assessment. On 5/20/14 at 2:55 PM, Employee C, Registered Nurse (RN) indicated the visits above did not follow the plan of care. 2. Clinical record #12, SOC 10/23/13 with a	G 170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	**425 S JOLIET ST STE 312 DYER, IN 46311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 170	Continued From page 43	G 170		

diagnosis of benign hypertension, evidenced no plan of care for the certification period of 4/21/14 - 6/19/14 on 5/29/14 at 10:15 AM. On 6/2/14 at 10 AM, the clinical record did contain a plan of care for the certification period of 4/21/14 - 6/19/14. This plan of care evidenced the skilled nurse was to visit the patient 1 times a week for 9 weeks to assess pain level, instruction on shortness of breath, weekly weights, assess and instruct on pain management, proper body mechanics and safety measures, to instruct on proper foot wear when ambulating, and to encourage the patient to see a podiatrist. No skilled nurse visits were completed in the clinical record.

a. On 5/29/14 at 10:15 AM, Employee C indicated the plan of care had not been completed and was not part of the clinical record and that skilled nurse visits were not in the record.

b. On 5/29/14 at 2:00 PM, Employee I, RN, was observed to have a blank piece of papers with visit notes for the past two months noted on this paper. She indicated that she did not document the visit until later at home. This paper was divided into about 8 sections and vital signs and the date were recorded. The paper did not indicate what part of the plan of care had been completed besides vital signs. There was no pain assessments or instructions for proper foot wear noted.

c. On 6/3/14 at 2 PM, Employee A indicated that the skilled nurse visits were missing from the record and documentation of a visit should be on a visit note or in the software program for skilled nurse visits used by the agency. Employee A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 170	Continued From page 44	G 170		

indicated Employee I had not been documenting her skilled nurse visits timely or according to policy.

3. Clinical record #13, SOC 3/29/14, evidenced a plan of care for the certification period of 3/29/14 - 5/27/14 that was electronically signed by Employee I on 3/25/14. The physician signed this plan of care on 5/10/14. Skilled nurse visits were made on 4/15/14, 4/22/14, 4/29/14, 5/9/14, 5/17/14, 5/20/14, and 5/27/14. There was no frequency of skilled nurse visits on this plan of care.

On 5/30/14 at 2:25 PM, Employee C indicated the skilled nurse had not followed the plan of care.

4. Clinical record #14 with a diagnosis of wound disruption evidenced two starts of care. One occurred on 8/12/13 and the other on 2/26/14. The record evidenced a plan of care for the certification period of 12/10/13 - 2/7/14, which was signed on 1/16/14. There was no other plan of care after this certification period. There were no orders for Skilled nurse visits which were documented on 2/18/14 and 3/7/14. An oasis start of care assessment completed by the RN on 2/26/14.

On 5/30/14 at 9:45 AM, Employee C indicated that there was no plan of care for the skilled nurse visits that occurred on 2/18/14 and 3/7/14 and the oasis start of care assessment completed by the RN on 2/26/14.

5. Clinical record #16, start of care 10/23/13 and diagnosis of bronchitis, evidenced the skilled nurse used triple antibiotic ointment on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 170	Continued From page 45	G 170		

patient's skin tear on without obtaining an order on 5/13/14 at 11:35 AM. It was not documented where the skin tear was.

On 6/2/14 at 11:20 AM, Employee A, the administrator, indicated there was no order for this treatment.

6. The agency policy titled "Scope of Practice" with no effective date stated, "Agency will provide services that are in compliance with acceptable professional standards for the Home Care Industry as well as the state and federal laws and identified agency performance improvement standards ... patient care will be provided under the plan of care established by a physician ... agency staff will deliver services based on each patient's unique and individual needs."

7. The agency policy titled "Plan of Care" with an effective date stated, "Home care services are furnished under the supervision of the patient's physician. the plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. .... The plan will be consistently reviewed to ensure that the patient needs are met, and updated as necessary at least every 60 days ... An individualized plan of care signed by the physician shall be required for each patient receiving home health and personal care services. The plan of care shall be completed in full to include ... type, frequency, and duration of all visits, services ... medications, treatments, procedures ... treatment goals ... signed physician orders will be reviewed by the attending physician and agency personnel as often as the severity of the patient's condition requires, but at least one time every 60 days. Professional staff alert the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 170	Continued From page 46 physician to any changes that suggest a need to alter the plan of care. Verbal telephone orders shall be obtained from the patient's physician for changes in the plan of care." 8. The agency policy titled "Skilled Nursing Services" with no effective date stated, "Skilled nursing services will be provided by a Registered Nurse or a Licensed Practical / Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care [Physician's Orders]. In determining whether a service requires the skills of a Nurse, the inherent complexity of the service, condition of the patient, and accepted standards of medical and nursing practice will be considered ... The registered nurse a. Performs the initial assessment visit, b. Regularly reevaluates the patient needs, and coordinates necessary services c. Initiates the plan of care and necessary revisions and updates to the plan of care and the care plan d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures e. informs the physician and other personnel of changes in the patient condition and needs ... prepares clinical and progress notes."	G 170		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on clinical record and document review and interview, the agency failed to ensure the	G 172		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 172	Continued From page 47 registered nurse reevaluated the patient's needs when the patient returned home from a hospital admission in 1 of 12 records reviewed (patient #14). The findings include 1. Clinical record #14, start of care 8/12/13, failed to evidence a comprehensive assessment had been completed within 48 hours of the patient's discharge from the hospital for treatment of a failing permacath. The record failed to evidence the patient had been discharged when entering the hospital. 2. A document titled "Community Healthcare System" and dated 2/21/14 evidenced the patient had been hospitalized from 2/21/14 - 2/23/14 for a failing permacath. 3. On 5/30/14 at 2:26 PM, Employee C indicated the patient had been discharged from the hospital on 2/23/14 and had not been reevaluated when he/she returned home.	G 172		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the registered nurse coordinated patient care for 7 of 12 records reviewed (12, 14, 15, 16, 17, 21, and 22) and	G 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 48	G 176		

promptly alerted the physician to any changes that suggested a need to alter the plan of care for 1 of 12 records reviewed (#17).

Findings

1. On 5/28/14 at 11:50 AM, Employee C, the alternate director of nursing, indicated not sharing any patients with other agencies.

2. Clinical record #12, start of care (SOC) 10/23/13 with a diagnosis of benign hypertension, included a plan of care for the certification period of 4/21/14 - 6/19/14 and services of home health aide services, skilled nurse, and podiatrist. The clinical record failed to show coordination of care between the skilled nurse, the home health aide, or the podiatrist.

On 5/29/14 at 10:15 AM, Employee C indicated no coordination of care had occurred.

3. Clinical record #14, SOC 8/12/13 with a diagnosis of wound disruption, evidenced the patient was receiving dialysis services along with skilled nurse services. The clinical record failed to evidence coordination of care with the dialysis facility and the skilled nurse.

a. On 5/28/14 at 7 PM, patient #14 indicated being on home hemodialysis at SOC and completing this dialysis at home three times a week until switching to nocturnal hemodialysis in a nearby dialysis facility in December 2013. Patient #14 indicated telling the skilled nurse about this care received from a dialysis facility.

b. On 5/30/14 at 9:45 AM, Employee C indicated there was no coordination of care noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 49	G 176		

in the record between the skilled nurse and dialysis facility.

4. Clinical record #15, SOC 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 2/19/14 - 4/19/14 and 4/20/14 - 6/18/14. The plan of care for 2/19/14 - 4/19/14 was signed on 5/19/14 by the physician. The services ordered were home health aide and skilled nurse services. This record evidenced the home health aide was to visit two times a week for 9 weeks for these certification periods. According to employee A on 5/29/14 at 12:05 PM, the home health aide had been visiting the patient but had not turned in documentation since December 2013. The administrator was aware but the concern was not corrected or documented. The record failed to evidence coordination between the skilled nurse and home health aide.

a. On 5/29/14 at 12:05 PM, Employee A was called by phone with Employee C and Employee R present. Employee A indicated Employee C was sent to patient #15's home to check if Employee S, HHA, was still caring for this patient under the agency's care. Employee A indicated that Employee S had terminated earlier this year, but did not give a date of termination. Employee A stated, "Why she never reported this, I don't know. There is a physician order, but she maintains contact with the patient. This is under investigation with our consultant." Employee A indicated that Employee I, RN, is responsible for this. Employee A indicated that Employee I had made progress in her work with the agency but still needed to make improvement with documentation with her care of the patients. Employee A indicated that Employee I does

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 50	G 176		

supervise the home health aides well and was in charge of supervision of this aide. The patient was pleased with this care from the agency.

b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.

c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Employee C indicated she was sent in by Employee A to check on the services of Employee S, HHA. Employee C indicated not knowing that the Employee S had resigned. She only knew that no documentation had been sent in for months from the Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services.

d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and Employee C. She indicated still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in trouble.

e. A document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 51	G 176		

since 12/13." This included the signature of Employee A, administrator.

F. Three documents were evidenced to be home health aide care plans and were dated on 12/18/13, 2/18/14, and 4/18/14.

5. Clinical record #16, SOC 10/23/13 and diagnosis of bronchitis, failed to evidence coordination of care with an agency which provided homemaker services. Also an order for a social work evaluation on 4/21/14 evidenced the patient had refused. However, the order and refusal did not discuss any details about how the order was refused and if the social worker or physician were aware of the refusal. The record failed to evidence coordination of care with the other agency.

a. On 6/2/14 at 10:30 AM, Employee CC, licensed practical nurse, indicated the patient was also seen by a home health agency that provided homemaker services.

b. On 6/2/14 at 11:05 AM, the administrator indicated the patient had refused social work services and there was no other documentation about this refusal.

6. Clinical record #17, start of care 10/2/12 with a certification period of 4/3/14 - 6/1/14, included an order on the plan of care that stated, "Physician's order, 4/2/14, MSW [Master's of Social Work] eval [evaluation]" This was dated 4/2/14 and signed by Employee A, administrator and director of nursing, and not signed by the physician. The patient had a primary diagnosis of benign hypertension. The record failed to evidence coordination of care between the social worker or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 52	G 176		

the nurse.

a. On 5/30/14 at 4:45 PM, Employee C, the alternate administrator indicated the social work evaluation was not in the record and that no care coordination had occurred with the social worker or the nurse.

b. On 6/3/14 at 1:30 PM, Employee A indicated the patient had refused to see a social worker. There was no order or other communication to the doctor or agency nurse about this care refusal and need for the patient to see the social worker.

c. On 5/30/14 at 4 PM, Employee I, Registered Nurse, indicated patient #17 had fallen on 4/24/14 and then cut self on arms on 4/29/14 with a knife. Employee E, the home health aide, called with an update. The nurse did not write any notes on this incident and did not write a transfer oasis. An informal caregiver took the patient to the emergency room where the patient was admitted and stayed several days. Clinical record #17, start of care 10/2/12, failed to evidence the physician had been notified regarding of the fall and self cutting.

7. Clinical record #21, SOC 10/4/13 and discharge on 3/25/14 and diagnosis of brain neoplasm, included a plan of care for the certification period of 2/1/14 - 4/1/14. The payment source was listed as Medicare. This plan of care indicated the patient was to receive skilled nurse visits 1 - 2 X weekly for 9 weeks and HHA visits for personal care including showers 1 - 2 times a week for 9 weeks. There were also HHA visits documented for 3/25/14, 4/3/14, 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 53	G 176		

4/24/14 after the discharge of this patient. There was an aide care plan dated on 1/30/14 that had no tasks for the home health aide to complete.

On 6/3/14 at 7:45 AM, patient #21 indicated not knowing he / she was receiving services from the home health agency. Patient #21 indicated not being aware of being discharged. There was no care communication that showed the patient had been discharged in the record.

8. Clinical record #22, SOC 10/1/13 and a diagnosis of paraplegia, included a plan of care for the certification period of 3/30/14 - 5/28/14 and payment source as Medicare. Included in the record were HHA visits from record #21 with the name of patient #21 documented. Ordered on this plan of care was the skilled nurse frequency of 1 time week for 9 weeks and HHA 2 times a week for 9 weeks. HHA visits occurred on 4/2/14, 4/4/14, 4/8/14, 4/10/14, 4/15/14, 4/17/14, 4/23/14, 4/25/14, 4/29/14, 4/30/14, 5/1/14, 5/7/14, 5/9/14, 5/13/14, and 5/15/14. SN visits occurred on 3/25/14, 4/10/14, 4/23/14, 4/30/14, 5/7/14, 5/14/14, and 5/21/14. HHA visits documented as to patient #21 were also in this record. These were from the following dates: 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, 4/24/14, 4/30/14, 5/2/14.

a. On 6/3/14 at 10:25 AM, Employee W, registered nurse, indicated that patient #22 was the only one of patients #21 and #22 receiving home health aide services. Patient #21's visits were used for patient #22. Employee W indicated he was the primary nurse visiting patient #22 and conducting aide supervision. There was no documentation of care communication in the record between the services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 176	Continued From page 54 b. On 6/3/14 at 1:05 PM, the administrator indicated that she was looking into this situation with patients #21 and #22. She stated, "We are not benefiting from this. [The patient] has private pay." 9. The agency policy titled "Coordination of Patient services" with no effective date stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current Care plans and written and verbal interaction ... Interdisciplinary care conferences shall be conducted as often as necessary to respond to changes in the patient's needs, services, care, or goals ... Ongoing care conferences shall be conducted to evaluate the patient's status and progress." 10. The agency policy titled "Skilled Nursing Services" with no effective date stated, "The registered nurse a. Performs the initial assessment visit, b. Regularly reevaluates the patient needs, and coordinates necessary services."	G 176		
G 202	484.36 HOME HEALTH AIDE SERVICES This CONDITION is not met as evidenced by: Based on clinical record review, personnel record review, policy review, and interview, it was determined the agency failed to ensure the home health aide had completed a competency evaluation prior to furnishing services in 1 of 4	G 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 202	Continued From page 55 home health aide files reviewed with the potential to affect all the patients that receive aide services from employee U (see G 212), failed to ensure home health aides were evaluated annually in 2 of 4 home health aide files reviewed with the potential to affect all the patients of the agency (see G 214), and failed to ensure the registered nurse had made a supervisory visit to the patient's home at least every two (2) weeks in 2 of 9 records reviewed of patients that received home health aide and skilled services creating the potential to affect all of the agency's patients that receive skilled and home health aide services (See G 229). The cumulative effect of these systemic problems resulted in the agency's inability to ensure safe home health aide care was provided as required by the Condition of Participation 484.36 Home health aide services.	G 202		
G 212	484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section. This STANDARD is not met as evidenced by: Based on personnel file and policy review and interview, the agency failed to ensure the home health aide had completed a competency evaluation prior to furnishing services in 1 of 4 home health aide files reviewed (U) with the potential to affect all the patients that receive aide services from employee U.	G 212		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 212	Continued From page 56 Findings 1. Employee U, Home Health Aide, date of hire 4/9/09 and first patient contact in 2009, failed to include a competency skills evaluation had been completed upon hire. 2. The agency policy titled "Home Health Aide services" with no effective date stated, "Only home health aides who meet required standards will provide direct care." 3. On 5/29/14 at 12:21 PM, Employee C, RN, indicated the personnel records were not complete.	G 212		
G 214	484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA must complete a performance review of each home health aide no less frequently than every 12 months. This STANDARD is not met as evidenced by: Based on personnel file and policy review, the agency failed to ensure the home health aide had an annual evaluation in 2 of 4 home health aide files reviewed (S and U). Findings 1. Employee S, home health aide (HHA), date of hire 8/10/07 and unknown first patient contact, failed to evidence an annual evaluation had been completed since 2012. 2. Employee U, HHA, date of hire 4/9/09 and first patient contact in 2009, failed to include an	G 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 214	Continued From page 57 annual evaluation since 2010 and a competency skills evaluation had been completed upon hire. 3. The agency policy titled "Performance Evaluations" with no effective date stated, "A competency based performance evaluation will be conducted for all employees after 1 year of employment and at least annually thereafter."	G 214		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the registered nurse had made a supervisory visit to the patient's home at least every two (2) weeks in 2 of 9 records reviewed of patients (#12 and #15) that received home health aide and skilled services creating the potential to affect all of the agency's patients that receive skilled and home health aide services. Findings 1. Clinical record #12 evidenced home health aide (HHA) services had been ordered 1- 2 times a week for 9 weeks during the certification period of 4/21/14 - 6/29/14 and skilled nurse had been provided 1 - 2 times a week for 9 weeks. The record evidenced that no supervisory visits had been provided from 4/21/14 - 5/29/14 by the registered nurse.	G 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 58	G 229		

On 5/29/14 at 10:15 AM, Employee C, Registered Nurse, indicated the supervisory notes were missing from the record.

2. Clinical record #15, Start Of Care 8/23/13 and a diagnosis of diabetes mellitus, included plans of care for the certification periods of 12-21-13 - 2-18-14 (HHA to visit 1 - 2 times a week and skilled nurse 1 - 2 times a week), 2/19/14 - 4/19/14 (HHA 2 times a week and SN 1 times a week, and 4/20/14 - 6/18/14 (SN one times a week). The plan of care for 2/19/14 - 4/19/14 was signed on 5/19/14 by the physician. The home health aide had been visiting the patient but had not turned in documentation since December 2013. The administrator was aware but the concern was not corrected or documented. Home health aide visits had been made since December 2013 with no documentation in the record. The registered nurse had not supervised these visits during this time.

a. On 5/29/14 at 12:05 PM, Employee A, administrator, was called by phone with Employee C and Employee R present. Employee A indicated that Employee C was sent to patient #15's home to check if Employee S, HHA, was still caring for this patient under the agency's care. Employee A indicated that Employee S had terminated earlier this year, but did not give a date of termination. Employee A stated, "Why she never reported this, I don't know. There is a physician order, but she maintains contact with the patient. This is under investigation with our consultant." Employee A indicated that Employee I, Registered Nurse, is responsible for this. Employee A indicated that Employee I has made progress in her work with the agency but still

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 59	G 229		

needs to make improvement with documentation with her care of the patients. Employee A indicated that Employee I does supervise the home health aides well and was in charge of supervision of this aide. However, the employee had not looked at any documentation of the aide's visits. The patient was pleased with this care from our agency.

b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15.

c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Patient #15 was happy with the services from Incare and the aide. Employee C indicated that she was sent in by Employee A to check on the services of an Employee S, HHA. Employee C indicated not knowing that Employee S had resigned. She only knew that no documentation had been sent in for months from Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services.

d. On 5/30/14 at 11:55 AM, Employee S called via telephone and spoke to writer and Employee C. She indicated still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 60 trouble. e. A clinical document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13 " This included the signature of Employee A, administrator.	G 229		
G 330	484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary This CONDITION is not met as evidenced by: Based on clinical record and document review and interview, it was determined the agency failed to maintain compliance with this condition to ensure the registered nurse completed a review	G 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 330	Continued From page 61 of all medications the patient was taking for 4 of 12 records reviewed (See G 337), a resumption of care comprehensive assessment had been completed within 48 hours of the patient's return home from a hospital admission of 24 hours or more in 1 of 12 records reviewed creating the potential to affect all the patients who were hospitalized (see G 340), and the comprehensive assessment had been updated at the time of discharge or transfer from the agency in 3 of 4 records reviewed with transfers or discharges (see G 341). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.55 Comprehensive Assessment of Patients.	G 330		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the registered nurse completed a review of all medications the patient was taking for 4 of 12 records reviewed (7, 13, 14, and 15). Findings 1. Clinical record #7, start of care (SOC) 7/26/13 with a diagnosis of open wound of the buttock,	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 62	G 337		

included a medication profile reviewed on 5/21/13 (prior to the start of care) which failed to include the reasons for as needed medications to be given including antibiotic ointment, polyethylene glycol, and hydrocodone with Tylenol. This medication profile listed the dosages under the routes for every medication included on the profile.

On 5/30/14 at 2:55 PM, Employee C, Registered Nurse (RN), indicated the medication profile was in error.

2. Clinical record #13, SOC 9/30/13 with a diagnosis of chronic pain, included a medication profile reviewed on 5/27/14 which failed to evidence a complete medication list. Fentanyl patch was listed without the dose, frequency, or route of administration.

On 5/30/14 at 2:26 PM, Employee C indicated the medication list failed to include the dose, frequency, and route of administration for the Fentanyl.

3. Clinical record #14, SOC 8/12/13 with a plan of care for the certification period of 12/10/13 - 2/7/14, failed to evidence a medication review had occurred since 10/10/13.

On 5/30/14 at 9:50 AM, Employee C indicated the medication profile had not been updated every 60 days.

4. Clinical record #15, SOC 8/23/13 and a diagnosis of diabetes mellitus, failed to evidence the medication profile had been reviewed.

On 5/30/14 at 11 AM, Employee C indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 63 the medication profile had not been reviewed.	G 337		
G 340	484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests. This STANDARD is not met as evidenced by: Based on clinical record and document review and interview, the agency failed to ensure a comprehensive assessment had been completed within 48 hours of the patient's return home from a hospital admission of 24 hours or more in 1 of 12 records reviewed creating the potential to affect all the patients who were hospitalized (patient #14). The findings include 1. Clinical record #14, start of care 8/12/13, failed to evidence a resumption of care comprehensive assessment had been completed within 48 hours of the patient's discharge from the hospital for treatment of a failing permacath. 2. A document titled "Community Healthcare System" and dated 2/21/14 evidenced the patient had been hospitalized from 2/21/14 - 2/23/14 for a failing permacath. 3. On 5/30/14 at 2:26 PM, Employee C indicated the patient had been discharged from the hospital on 2/23/14 and had not had a resumption of care comprehensive assessment completed within the	G 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 340	Continued From page 64 required time frame.	G 340		
G 341	484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. This STANDARD is not met as evidenced by: Based on clinical record and document review and interview, the agency failed to ensure the comprehensive assessment had been updated at the time of discharge or transfer from the agency in 3 of 4 records (#14, #16, #17) reviewed with transfers or discharges noted. The findings include 1. Clinical record #14 evidenced skilled nursing services had been provided 1 - 2 times a week for 9 weeks during the certification period of 12/10/13 - 2/7/14 and also were provided on 2/18/14 and 3/7/14. The patient had been transferred to the hospital on 2/21/14 and returned home on 2/23/14. Neither a transfer or discharge assessment had occurred to show that the patient had been discharged. However, an oasis start of care assessment was completed by the RN on 2/26/14. The record was kept as a closed record in a file cabinet for closed records, but failed to show that any discharge assessment or summary had occurred. It was not known that the patient had been discharged. a. A document titled "Community Healthcare System" and dated 2/21/14 evidenced the patient had been hospitalized from 2/21/14 - 2/23/14 for a failing permacath.	G 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	425 S JOLIET ST STE 312 DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 341	Continued From page 65	G 341		

b. On 5/28/14 at 7 PM, patient #14 indicated that services stopped and that he / she had not been notified of this change in the plan of care.

c. On 5/30/14 at 2:26 PM, Employee C indicated the patient had been discharged from the services of the agency and there was no discharge assessment or discharge summary. The patient had been transferred to the hospital on 2/21/13 and returned home on 2/23/14.

2. Clinical record #17, start of care 2/2/14 with a certification period of 4/3/14 - 6/1/14, failed to evidence a transfer or discharge assessment had been completed by the skilled nurse after the patient had been transferred to the hospital on 4/29/14.

a. On 5/30/14 at 4:30 PM, Employee I, Registered Nurse, indicated the patient had been transferred to the hospital on 4/29/14 and was discharged from the hospital on 5/5/14. No transfer or discharge assessment or summary had been completed at that time.

b. On 6/2/14 at 11:42 AM, Employee A indicated the patient had been discharged and was now in an assisted living in Michigan City.

3. Clinical record #21, SOC 10/3/13 and discharge on 3/25/14 and diagnosis of brain neoplasm, included a plan of care for the certification period of 2/1/14 - 4/1/14. The payment source was listed as Medicare. This plan of care indicated the patient was to receive skilled nurse visits 1 - 2 times weekly for 9 weeks and home health aide (HHA) visits for personal care including showers 1 - 2 times a week for 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157596	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INCARE HOME HEALTHCARE INC	**425 S JOLIET ST STE 312 DYER, IN 46311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 341	Continued From page 66 weeks. There were also HHA visits documented for 3/25/14, 4/3/14, 4/9/14, 4/11/14, 4/16/14, 4/18/14, 4/22/14, and 4/24/14 after the discharge of this patient. There was an aide care plan dated on 1/30/14 that had no tasks for the home health aide to complete. On 6/3/14 at 7:45 AM, patient #21 indicated not knowing he / she was receiving services from the home health agency. Patient #21 indicated not being aware of being discharged. There was no communication that showed the patient had been discharged in the record.	G 341		